

Education Commission for Foreign Medical Graduates
(ECFMG)

ATT: N. Emmanuel G. Cassimatis, M.D.
President and Chief Executive Officer, ECFMG
3624 Market Street
Philadelphia, PA 19104-2685

CONFIDENTIAL

April 1, 2014

Richard Katz
ECFMG ID: #06314751

Subject: Six Attempt Limit for USMLE Examinations: USMLE STEP I

Dear ECFMG:

I am writing to appeal the six attempt limit rule instituted by ECFMG in August of 2011. Although I am able to register for USMLE Step 2 CK as well as Step 2 CS, I am no longer able to register for USMLE Step 1 as the ECFMG website tells me that I have *exceeded my attempt limit* for this particular step. There are factors that contributed to my current situation that I need to address to ECFMG at this time. What follows are the facts, and where possible I have included support documentation to substantiate these facts.

I was diagnosed with bipolar disorder in March of 2013. Dr. Samuel Garloff from The ReDCo Group in East Stroudsburg, Pa, has been my treating psychiatrist since May of 2013. Currently I am being treated with Seroquel 400mg Lithium Carbonate 300mg and Cymbalta 60mg with good effect.

I have made multiple attempts at USMLE Step I since graduating Medical School in 2004. My last attempt was November 12, 2013 where I failed by six points receiving a 182, the attempt before last I received a 185 failing by three points.

In 2005 I began searching for answers to my difficulties I consulted a psychiatrist by the name of Ann E. Hedberg from The Center For Emotional Care in Salem, VA (i. encl. 1). Dr. Hedberg diagnosed me with ADHD and prescribed Adderall 20mg qd. In 2005 I also underwent psychological testing at St. John's University Center For Psychological

Services located in Jamaica, New York. Upon completion of their assessment St. John's recommended the following : *1) Richard would benefit from Psychotherapy that addressed his ADHD, as well as his symptoms of anxiety and depression. 2) Richard would benefit from extended testing times on exams 3) Richard could seek out a tutor to help him improve his study skills (i. encl. 2).*

I applied to The National Board of Medical Examiners (NBME) Disability Services in 2005 for exam accommodations and extended time for the USMLE Step I. I was assigned a case coordinator from NBME by the name of Maria Fuentes. Based on previous Psychological Reports and Psychiatric Evaluation in 2005 it was determined that I suffered from ADHD as well as anxiety and depressed mood all resulting in problems with working memory and executive function (**i. encl. 3**). The NBME under the direction of J. Abram Doane, MA, JD did not grant accommodations at this time because the diagnosis of ADHD did not result in developmentally deviant impairment in the following two domains: *1) The documentation that was submitted did not demonstrate significant and persistent functional impairment over time and across situations. 2) Nor did it demonstrate that I was significantly limited in my ability to handle normal developmental, academic and social tasks.* It was explained in the NBME letter dated March 13, 2006 that this criteria must be met in order to qualify for exam accommodations through NBME (**i. encl. 4**).

The above conclusion was only a superficial assessment of my early developmental and academic history. In fact, I suffered from neurological problems during childhood, a condition known as rolandic epilepsy. My seizures were treated with Phenobarbital (**i. encl. 5**). Neurological EEG reports obtained from The New York Hospital from 1981 when I was 11 years old state the following impression: *a seizure disorder with right hemisphere focal features.*

Recent studies in peer reviewed medical journals argue that children with rolandic epilepsy are at increased risk for developing problems with reading and memory skills as compared to age and gender matched controls. Very recent studies have concluded that the critical phase of brain development is between 8-14 years and suggest that rolandic epilepsy should NOT be considered a benign condition as previously thought. Recent fMRI studies have shown impaired interplay between motor and language networks, and aberrant functional connectivity associated with poorer language performance in individuals afflicted with rolandic epilepsy (**i. encl. 6**).

There were deficits due to my epilepsy as evidence by speech impairment during childhood, that required speech therapy and special accommodations and intervention through the NYC Board of Education. Also there were academic difficulties especially with linear sequential thinking, reading comprehension and recall. *There have been formal and informal accommodations throughout my academic history (i. encl. 7).*

Neurological exam performed by Dr. Lerner a Neurologist in Astoria, New York in 2007 revealed left ankle clonus (**i. encl. 8**). Ankle clonus is usually caused by a pyramidal tract lesion (Differential Diagnosis in Primary Care pg 47). The fibres of the pyramidal tracts are axons of cells situated in the brain in the region of the fissure of Rolando or motor neuron (New International Encyclopedia Vol 16 pg 736). If the focus lies near the fissure of Rolando, the epilepsy is termed Rolandic (Language & Epilepsy 2008). Somatosensory Evoked Potentials performed by Dr. Lerner demonstrated a delay of cortical response to both left upper and lower extremity stimulation, this is consistent with a right brain focus.

Lastly, and most importantly, there is an increased risk for depression and anxiety in children with epilepsy. Depression and anxiety disorders have been identified in these patients prior to the start of treatment, and studies with sibling control subjects found higher rates of mood disorders like bipolar disorder early after diagnosis and the initiation of treatment. This raises the possibility that the psychiatric and seizure presentation have a common neurophysiologic etiology (Austin et al 2001).

The diagnosis of ADHD in Dr. Garloff's professional opinion is inaccurate. Dr. Garloff explained to me that the likelihood of having both ADHD as well as Bipolar Disorder is remote and highly unlikely. I have difficulty making transitions, I am distractible, inattentive, anxious and at times am overly perfectionist. These symptoms can be easily confused with ADHD. I also have difficulty organizing and breaking things down, accomplishing complex tasks in short increments of time is often difficult for me. I also have problems focusing and energy levels that tend to wax and wane (often according to the season) all of these symptoms are indicative of bipolar disorder. **For these reasons special accommodations in school and the workplace, not to mention timed eight hour standardized exams are necessary for my success.**

I learned for the first time in March of 2013 that I suffer from bipolar disorder. Because of my bipolar disorder and the fact that I was misdiagnosed with ADHD in 2005, I am eligible for accommodations in academic and work environments. Specifically by two federal laws: Section 504 of the Rehabilitation Act of 1973; and the more powerful statute enacted in 1975 and reauthorized in 1997 known as the Individuals with Disabilities Education Act (IDEA).

Therefore, because exam accommodations were not granted in 2005 by NBME under a diagnosis of ADHD and NOT bipolar disorder, I am appealing to ECFMG to consider the fact that my diagnosis of bipolar disorder was first discovered in March of 2013 and under federal Statute I was never given a fair opportunity to

properly sit for USMLE Step I with exam accommodations. The last administration of USMLE Step I on November 12, 2013 I failed by six points, insight into my bipolar disorder at this time was certainly compromised by denial, my reality at this time was that I was only three points away from passing as my previous score was a 185. I was not aware that bipolar disorder fell under disability statute, nor did I know that I was eligible for exam accommodations under the disability act.

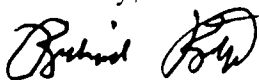
In order to level the playing field I deserve to have the six attempt limit rule overturned and exam accommodations granted for USMLE Step I and all future USMLE steps there after. Citing the following case as a precedent: **Rush IV v. National Bd. Of Medical Examiners** 268 F. Supp.2d 673 (N.D. Tex. 2003) (granting preliminary injunction ordering Board to grant medical student double time on board exam based on learning disability that substantially limited his ability to read and learn, student had history of formal and informal accommodations).

Thus far, only my disability has been tested throughout this process of medical licensure and I have not been afforded an opportunity to properly demonstrate mastery of the information on the USMLE through proper exam accommodations. *This has culminated in a cascade of problems related to career, finances, as well as my personal and mental well being for the past nine years.* It is obvious that my scores have reached a plateau with regard to the USMLE Step I Exam, I have persevered as far as my disability will permit.

It is for these reasons that I am appealing to ECFMG to remove the six attempt rule from my ECFMG profile so that I may once again register for USMLE STEP I, and apply through NBME for exam accommodations under the diagnosis of bipolar disorder.

Please contact me by phone if you have any additional questions.

Sincerely,



Richard Katz

ECFMG ID# 06314751

3364 Parker Lane
East Stroudsburg, Pa 18301
(570) 517-9314

i. encl. (additional documentation provided)

- (1) Ann E. Hedberg, MD dated May 20, 2005
- (2) St. John's Psychological Assessment Report dated 6/6/2005 through 06/7/2005).
- (3) Fred L. Holtz Psychological Services, PC dated 11/28/2005
- (4) NBME Accommodations Denial Letter dated 3/13/2006
- (5) EEG report from The New York Hospital dated 4/22/1981
- (6) Epilepsy Res. 2013 Dec, 107(3): 253-62. Doi. 10.1016).
- (7) William Lupardo Director for the Office of Services for Students with Disabilities at the State University of New York College at Old Westbury
- (8) Neurological Report by Paul Lerner, MD dated May 15th 2007

cc: ECFMG

N. Emmanuel G. Cassimatis, M.D.

President and Chief Executive Officer, ECFMG

Chair, Board of Directors, FAIMER

cc: NBME

- J. Abram Doane, MA, JD

- Catherine Farmer, Psy.D

ADA Compliance Officer: Testing Programs

State of Pennsylvania, County of Monroe

On this day, appeared before me in person

Richard Katz

to me known to be the person(s) described in and who performed the within and preceding document, and accepted that he/she signed the same as his/her voluntary act and action, for the uses and purposes mentioned within.

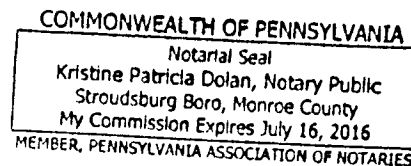
Witness my hand and official seal hereto affixed

this 3rd day of April, 2014

Kristine Patricia Dolan

Notary Public in and for the State of Pennsylvania.

My commission expires July 16, 2016.



(i. encl. 1)

Ann E. Hedberg, MD
1215 Byrd Ave
Richmond, VA 23226
(804) 441-3003

Letter Ann E. Hedberg, MD
dated May 20, 2005

May 20, 2005

Testing Coordinator, Disability Services
National Board of Medical Examiners
3750 Market Street
Philadelphia, PA 19104-3190

Dear Sir:

I am a Psychiatrist licensed in the State of Virginia and board certified in Psychiatry. I examined Richard Katz on Feb. 11, 2005 and found he met the criteria for the diagnosis of Attention Deficit Hyperactivity Disorder combined type.

He demonstrates failure to give close attention to details, difficulty in sustaining attention in tasks, does not seem to listen when spoken to directly, often does not follow through on instructions, has difficulty organizing, is reluctant to engage in tasks that require sustained mental effort, often loses things necessary for tasks, easily distracted by extraneous stimuli, is forgetful in daily activities, fidgets with hands or feet, has a subjective feeling of restlessness, talks excessively, demonstrates increased energy, has difficulty waiting his turn, often interrupts, and often answers questions before the question is completed.

He has not been given accommodations in the past and subsequently has failed his exams on 3/31/05, 12/20/04, 12/26/03, 10/25/02, and 3/27/02. I believe it will be necessary to allow him extra time to complete the exam.

Sincerely,

Ann E. Hedberg MD
Ann E. Hedberg, M.D.

THE CENTER FOR EMOTIONAL CARE

Name: *Kathryn A. Smith*Date: *6/16/15*DOB: *3/10/72*

Referral Source:

Identifying Statement: *Seeking help for anxiety disorder*

HPI

Ms. Smith reports problems with anxiety disorder. She has been told that she has a generalized anxiety disorder. She has been told that she has a generalized anxiety disorder. She has been told that she has a generalized anxiety disorder.

She has been told that she has a generalized anxiety disorder. She has been told that she has a generalized anxiety disorder. She has been told that she has a generalized anxiety disorder.

She has been told that she has a generalized anxiety disorder. She has been told that she has a generalized anxiety disorder. She has been told that she has a generalized anxiety disorder.

Past Psychiatric History

She has been told that she has a generalized anxiety disorder. She has been told that she has a generalized anxiety disorder. She has been told that she has a generalized anxiety disorder.

PMH

She has been told that she has a generalized anxiety disorder. She has been told that she has a generalized anxiety disorder. She has been told that she has a generalized anxiety disorder.

PSH

She has been told that she has a generalized anxiety disorder. She has been told that she has a generalized anxiety disorder. She has been told that she has a generalized anxiety disorder.

CNST

Allergies

Current Medication

Substance Abuse

Social History

Developmental History

Past Family Psychiatric History

MSE

Appearance

Eye Contact good moderate poor

Motor Movement normal decreased increased

Impulse Control good moderate poor

Speech

Mood

Affect

Thought Processes linear goal directed disorganized confused LOA tangential

Circumferential

Thought Content SI yes no with intent with plan passive active

HI yes no

Delusions

Hallucinations A V O T

Memory

Judgment

Insight

Estimated Intelligence

Impression:

The patient is a 30-year-old male with a history of bipolar disorder, currently in a manic episode. He is presenting with symptoms of mania, including elevated mood, increased energy, and decreased need for sleep. He is also exhibiting some psychotic features, such as delusions and hallucinations. The patient is currently being treated with a combination of mood stabilizers and antipsychotics. He is being evaluated for admission to a psychiatric hospital for further treatment and monitoring.

Working Diagnosis:

Axis I *Depressive disorder, single episode*Axis II *None*Axis III *None*Axis IV *Stressor: financial problems, job loss*Axis V *not applicable*

Plan:

1) *Antidepressant therapy*2) *OTC analgesic**John E. DeBogus*

Name: Richard Kuby DOB: 3/10/72

[illegible]

St. John's Psychological
Assessment Report dated
6/6/2005 through 06/7/2005).



CENTER FOR PSYCHOLOGICAL SERVICES
152-11 UNION TPKE
FLUSHING, NY 11367

Phone: 718-990-1900
E-Mail: psychcenter@stjohns.edu

Fax: 718-990-1586
Website: www.stjohns.edu

PSYCHOLOGICAL ASSESSMENT REPORT

NAME: Richard Katz

CHART #: TA-3579

DOB: 3/16/1970

DATES OF ASSESSMENT: 6/6/2005, 6/7/2005,
6/13/2005, 6/20/2005

AGE: 43

REASON FOR REFERRAL

The examinee was referred to the Center for Psychological Services to asses for the presence of ADHD and any other deficits that may be inhibiting him from passing the Medial Licensing Exam. The examinee reported that he was recently having difficulty passing the Medical Licensing Exam, which he failed several times. R was previously seen by a psychiatrist that stated that he met the criteria for ADHD combined type. R presented a letter from the psychiatrist stating that he exhibited symptoms consistent with ADHD Combined type.

INSTRUMENTS OF ASSESSMENT

Woodcock Johnson Reading Mastery Test Revised edition. Conner's Adult ADHD Rating Scale (CAARS). The Conner's Adult ADHD History Form, The Incomplete sentence Blank. The Thematic Apperception Test (TAT). The Beck Depression Inventory (BDI) 2nd edition. The Beck Anxiety Inventory (BAI). The State-Trait Anxiety Inventory. (STAI). Test of Variables of Attention (TOVA).

BACKGROUND INFORMATION

R is a 35 year old male who is preparing to re-take his Medical Licensing Examination. R reported that he has previously failed the exam five times. R reported that he has always struggled academically as a student. He also reported that he had difficulties taking in-class exams in medical school. Furthermore R reported that he felt as if his reading skills have recently diminished, which may have affected his performance on the Medical Licensing Exam.

Prior to medical school R dedicated his early education to studying fine arts. He attended The Parsons School of Design, where he earned a Bachelor of Fine Arts. R reported that he was in a gifted program during junior high school for his artistic abilities. Furthermore he reported that in high school and college he excelled as an artist. He explained that his academic difficulties occurred mostly in traditional academic courses (e.g. mathematics, science etc). After acquiring his degree from the Parson's School of Design he attended various colleges in order to complete the course prerequisites for medical school. He subsequently attended St. Matthew's University School of Medicine in Belize. R reported that he had struggled to pass his classes in medical school. R reported that at that time he was treated for Adjustment Disorder with Depressed Mood.

After completing his course requirements at St. Matthew's University School of Medicine, he returned to New York to take the medical Licensing Exam which he failed five times. R reported that he had difficulty concentrating during the latter portions of the exam, and often felt distracted during the test. He further explained that he also had similar difficulties when taking the Medical College Admissions Test (MCAT), prior to his admission to medical school. After repeatedly failing the Medical Licensing Examination, R reported that he began experiencing increased levels of anxiety and depression. He sought out treatment for this and was prescribed Venlafaxine in 2003. R stated that he took Venlafaxine for 1 year. R was also tested in 2003 at the St. Johns Center for Psychological Services to be evaluated for any learning deficits. The results indicated that there was no evidence of any learning deficits. In order to address his testing difficulties R was recently seen by psychiatrist who diagnosed him with ADHD. Consequently R was prescribed Adderall and Wellbutrin, which he is currently taking.

BEHAVIORAL OBSERVATION

R was seen for three sessions: the initial interview, and two testing sessions. He arrived approximately 25 minutes late for the initial session, and was on time for all subsequent sessions. He appeared well groomed and casually dressed to each session. He maintained appropriate eye contact during all sessions. R was also cooperative when responding to the tests questions on all the tests administered. During administration of the subtest Visual Auditory Learning on the WJ Reading Mastery Test, where he was required to associate words with several visually presented stimuli, R frequently asked to have the words repeated to him. He also appeared distracted during the learning phase of this task where the symbols were presented and the associated words were read to the examinee.

RESULTS OF ASSESSMENT

Intellectual functioning: R was administered the Woodcock Johnson Reading Mastery Test Revised edition, a test of general reading ability. R scored in the High Average range on the Total Reading Cluster (Standard Score = 112, 72nd percentile). The test is further comprised of three clusters that focus on different facets of reading skills (the Readiness Cluster, the Basic Skills Cluster, and the Reading Comprehension Cluster). The Readiness Cluster provides an index of skills necessary for beginning reading. The Basic Skills Cluster provides a broad measure of basic reading skills. The Reading Comprehension Cluster provides a broad measure of reading comprehension skills. R's score on the Readiness Cluster fell in the Low Average (Standard Score= 83, 12th percentile). His score on the Basic Skills Cluster fell in the High Average (Standard Score 119, 90th percentile). His score on the Reading Comprehension Cluster fell in the Average range (Standard Score = 100, 50th percentile). The subtest scores are provided in the addendum.

Personality functioning: R was administered the BDI 2nd edition a measure of depressive symptoms. R attained a score of 21 on the BDI that is indicative of a moderate level of depression. R was also administered two measures of anxiety (the BAI and the STAI). R exhibited a significant level of anxiety on the STAI which assesses general trait anxiety as well as his current level of anxiety. The items on the BAI mostly focused on physiological symptoms of anxiety; where as R did not endorse many physiological symptoms on the BAI.

R was administered the CAARS, a self report measure for ADHD. The CAARS is comprised of several indexes. The indexes on the CAARS assess ADHD symptomology

R's scores on all of the indexes ranged from the Much Above Average range to the Very Much Above average range. R's scores are summarized in the addendum.

R was also administered the TOVA, which is a computerized test that assess for attentional disorders. On this test the he was presented with two visual stimuli, the target and the non-target, over a set period of time. The examinee is required to press a button each time he is presented with the target stimuli. This task required the examinee to maintain sustained attention for a period of time while responding to the stimulus on a computer monitor. The TOVA yields several scores for four time periods of which the test is administered. R's pattern of responding across the trials on the TOVA was inconsistent. R appeared to attend to the stimulus for a brief period followed by a period of inaccurate erratic responding. After the period of inaccurate responses, R seemed to respond accurately to the stimulus, again followed by periods of inaccurate responding.

R was also administered several projective measures (the TAT, and the Incomplete Sentence Blank). On the TAT R was presented with several pictures and asked to create a dramatic story about the content

Passage Comprehension	Word Comprehension	Word Attack	Word Identification	Letter Identification
Visual-Auditory Learning Test	Summary of Woodcock Johnson Reading Mastery Test subtest scores			

104	97	123	111	85	87	Standard Score
-----	----	-----	-----	----	----	----------------

61	42	94	76	16	19	Percentile
----	----	----	----	----	----	------------

Reading Comprehension Cluster	Reading Comprehension Cluster	Basic Skills Cluster	Basic Skills Cluster
Readiness Cluster	Readiness Cluster	Cluster	

Measures the ability to study a short passage and identify a word missing from the passage. This task requires the subject to exercise a variety of comprehension and vocabulary skills. Measures reading vocabulary at different levels of cognitive processing. Measures the subject's ability to apply phonic structural analysis skills in order to pronounce words with a very low frequency of occurrence in the English Language. This test requires the subject to identify isolated words that appear in large type on the subject pages in the test book. Measures the ability to identify letters presented in uppercase and lowercase forms. Measures the ability to form associations between visual stimuli and oral responses.

Description

Total Reading Cluster	Reading Comprehension	Basic Skills	Readiness	Cluster
Summary of Woodcock Johnson Reading Mastery Test Cluster Scores				

112	100	119	83	Standard Score
-----	-----	-----	----	----------------

78	50	90	12	Percentile Rank
----	----	----	----	-----------------

109-114	98-102	114-125	75-90	95% Confidence Interval
---------	--------	---------	-------	-------------------------

ADHD Index	DSM-IV ADHD Symptoms	DSM-IV Hyperactive-Impulsive Symptoms	DSM-IV Inattentive Symptoms
Problems with Self Concept	Impulsivity/Emotional Lability	Hyperactivity/Restlessness	
Inattention/memory Problems	Index	Summary of CAARS Index Scores	

68	89	81	90	75	73	66	79	Standard Score
----	----	----	----	----	----	----	----	----------------

95-98	98+	98+	98+	98+	98+	95-98	98+	Percentile Range
-------	-----	-----	-----	-----	-----	-------	-----	------------------

Much Above Average Range	Very Much Above Average	Very Much Above Average	Very Much Above Average
Very Much Above Average	Very Much Above Average	Very Much Above Average	Much Above Average
Average	Very Much Above Average	Guideline	

and individuals in the pictures. Most of his responses on the TAT focused on themes of frustration, anxiety and avoiding frustrating or anxiety provoking situations. Overall his responses on TAT were concise and focused on describing the feelings of the characters in the photographs. Similarly many of his responses on the Incomplete Sentence Blank were concise and described a range emotions ranging from positive to negative.

IMPRESSIONS

The diagnosis most consistent with the examinee's presenting problems and test results is ADHD Predominantly Inattentive Type (DSM-IV-TR 314.00). This diagnosis is warranted by his performance on the CAARS and the TOVA, as well as his self report of ADHD symptoms (e.g. distractibility, and difficulty concentrating during exams). His scores on the CAARS are specifically indicative of ADHD symptomology. Furthermore his responses on the TOVA exhibit a pattern of inconsistent attention during a task.

Regarding Reading ability, his performance in the Woodcock Johnson Reading Mastery Test Revised edition suggests that his overall reading ability is in the High Average range. Nevertheless his score on the Readiness Cluster fell in the Low Average range. His scores on the Readiness cluster are likely due to his inability to maintain consistent attention to a task, as one of the tests (Visual-Auditory Attention) within this cluster require a learning phase where R seemed unable to attend during the learning portion of the task.

R also exhibited a significantly elevated level anxiety on the STAI. Moreover R reported experiencing a significant degree of anxiety in general. R also exhibited a moderate level of depression on the BDI. R's anxiety and depressive symptoms may also interfere with his test taking ability.

RECOMMENDATIONS

1. The patient would benefit from Psychotherapy that addressed his ADHD, as well as his symptoms of anxiety and depression.
2. The examinee would benefit from extended testing time on exams.
3. The examinee could seek out a tutor to help him improve his study skills.

Harald Magny M.A.

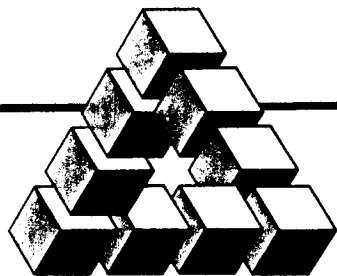
ExaminerPsychologist-in-Training

R. Morrissey, PhD, Director for
Dr. Sisenwien

Florence Sisenwien Ph.D.

Supervisor, Associate Director

1/6/14



HPStherapy.com • (516) 818-8383

(i. encl. 3)Fred L. Holtz Psychological
Services, PC dated 11/28/2005**HOLTZ
PSYCHOLOGICAL
SERVICES HPS***Advanced Approaches
Sensible Solutions*

400 South Oyster Bay Road • Suite 204 • Hicksville, NY 11801

ORIGINALLY WRITTEN IN NOVEMBER of 2005

TO: Maria Fuentez, Case Coordinator, Disability Services
National Board of Medical Examiners

Dear Maria Fuentez:

Richard Katz is a patient seen in my office on a regular basis. He is participating fully in the therapeutic process and is motivated to improve his coping skills. I have reviewed the comprehensive evaluation performed at St. John's University as well as other medical and psychological records. I have also performed a diagnostic interview in my office.

Richard Katz shows evidence of an Attention Deficit Disorder, specifically, impaired ability to concentrate, poor freedom from distractibility, and impaired working memory (the ability to retain several concepts in his mind simultaneously.) There is also evidence of significant anxiety, primarily related to his disabilities, as well as frequent depressed mood. These significant functional impairments impact his ability to concentrate, particularly when under time constraints. He requires additional time and provision for breaks in order to perform to his potential.

It is recommended that Richard Katz be allowed additional break time for the Clinical Knowledge portion of the Medical Boards, as well as extra time when possible. This would provide a fair assessment of his knowledge base and ability to perform.

If I can be of any further assistance, please feel free to contact this office directly.

Sincerely,

Fred L. Holtz, PhD
Executive Director

(i. encl. 4)

NBME Accommodations Denial
Letter dated 3/13/2006



National Board of Medical Examiners®
3750 Market Street
Philadelphia, PA 19104-3102
215.590.9500

CONFIDENTIAL

March 13, 2006

Richard Denis Katz
9050 Union Turnpike Apt 18-H
Glendale, NY 11385

RE: USMLE Step 2 CK & CS

USMLE ID#: 0-631-475-1

Dear Dr. Katz:

We have carefully reviewed your request for test accommodations for the **United States Medical Licensing Examination (USMLE) Step 2 Clinical Knowledge (CK) and Clinical Skills (CS)** and accompanying material in accordance with USMLE guidelines for examinees with disabilities and within the framework of the Americans with Disabilities Act (ADA). We consulted experts in the fields of Learning Disability and Mental Disorders to assist us in reviewing the documentation.

Accommodations are intended to provide equal access to the USMLE testing program for individuals who are covered under the Americans with Disabilities Act (ADA). A diagnostic label, in and of itself, does not establish coverage under the ADA. Prior receipt of accommodations for a particular activity does not guarantee that identical accommodations are indicated or will be available in all future settings and circumstances. Regulatory decisions and case law have established that the ADA covers individuals who are substantially limited in a major life activity as the result of a disability. Determination of whether an individual is substantially limited in functioning as compared to most people is based on assessment of the current impact of the identified impairment.

By definition, ADHD affects people over time and across situations in multiple domains, not in one circumscribed area such as test taking. The impact of the disorder needs to be evident in real world functioning and result in developmentally deviant impairment in at least two domains. Your documentation does not suggest significant and persistent functional impairment over time and across situations, nor does it demonstrate that you were significantly limited in the ability to handle normal developmental, academic and social tasks. To the contrary, the documentation you submitted indicates that you progressed through

elementary and grade school, earned a Bachelor's degree, and earned a MD degree, all apparently without accommodations.

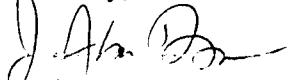
Furthermore, you provided little objective evidence or data indicating that you are currently functionally impaired to a degree that would rise to the level of a disability. No documentation was provided via faculty/supervisor comments, job performance evaluations, or through other sources of information verifying that you have shown significant impairment in one or more major life activities. The conclusions of your evaluators notwithstanding, the developmental evidence and current pattern of test results provided in your documentation offers little evidence to support the conclusion of significant impairment in one or more major life activities due to inattention, hyperactivity, and/or impulsivity.

Although your evaluators indicate that you are currently diagnosed with an anxiety and a depressive disorder, your documentation contains no evidence that these conditions impair your day to day functioning to a degree that would rise to the level of a disability. Performance on standardized tests and attending medical school are not defined by the law or accompanying regulations as major life activities. Working harder than others and performing below one's expectations on standardized examinations in a competitive academic environment are highly subjective judgments that even if possible to quantify, are not reflective of impaired functioning.

Therefore, after a careful review of all of your documentation, I must inform you that we are unable to provide you with the requested accommodations.

We will advise Applicant Services to process your exam application without test accommodations. You may inquire at usmlereg@nbme.org or call Applicant Services directly at (215) 590-9700 with any questions about your scheduling permit.

Sincerely,



J. Abram Doane, MA, JD
Manager, Disability Services
ADA Compliance Officer, Testing Programs

JAD/geb

Disability Services
215-590-9509
215-590-9422 (Fax)

(i. encl. 5)

EEG report from The New York
Hospital dated 4/22/1981

4-22-81	N8	KATZ, RICHARD
DATA (L.R., R.T., L.F., R.F., L.T., R.T.)	LESS THAN	M-162 71 32
11/7/81		EEG# 681
IF NO PLATE, PRINT NAME, AGE, AND HISTORY NO.		

Tracing was recorded on a Grass Model 8-16 channel EEG machine. 10-20 International System Electrode placement. 22 lead referential and bipolar recording performed on 4-22-81.

EEG REPORT

History:	Left sided focal seizures.
Medications:	Phenobarbital.
Condition of patient:	Awake, drowsy. Sedated with Chloral Hydrate.
General background organization & abnormalities:	The record is mildly disorganized. There is intermittent low to medium voltage 12 Hz alpha activity posteriorly and low and medium voltage beta superimposed with an anterior preponderance. 5-7 Hz theta activity is intermixed in the background. Intermittent sharp waves and spikes occ. bilaterally and independently from the right frontoparietal region.
Hyperventilation for 3mins:	Produced diffuse high voltage theta slowing.
Photic stimulation:	Produced no sustained driving.
Sleep:	12-14 Hz spindles, vertex sharp waves and K complexes occur. Occasional sharp waves are seen from each hemisphere.

IMPRESSION: Abnormal tracing characterized by mild background disorganization, intermittent right frontoparietal sharp waves and spikes suggesting a seizure disorder with right hemisphere focal features.

J. CEDARBAUM M.D.

Gail E. Solomon, M.D.
Director, Electroencephalography

[m-4-23-81
ob

43106

THE NEW YORK HOSPITAL

PubMed

(i. encl. 6)

Epilepsy Res. 2013 Dec, 107(3):
253-62. Doi: 10.1016/j.

Display Settings: Abstract

Epilepsy Res. 2013 Dec;107(3):253-62. doi: 10.1016/j.epilepsyres.2013.10.008. Epub 2013 Oct 23.

Aberrant functional connectivity between motor and language networks in rolandic epilepsy.

Beeseling RM, Overvliet GM, Jansen JF, van der Kruis SJ, Vlos JS, Ebus SC, Hofman PA, de Louw AJ, Albenkamp AP, Bakker WH.

Author information

INTRODUCTION: Rolandic epilepsy (RE) is an idiopathic focal childhood epilepsy with a well-established neuropsychological profile of language impairment. The aim of this study is to provide a functional correlate that links rolandic (sensorimotor) pathology to language problems using functional MRI.

MATERIALS AND METHODS: Twenty-three children with RE (8-14 years old) and 21 matched controls underwent extensive language assessment (Clinical Evaluation of Language Fundamentals). fMRI was performed at rest and using word generation, reading, and finger tapping paradigms. Since no activation group differences were found, regions of interest (ROIs) were defined at pooled (patients and controls combined) activation maxima and in contralateral homotopic cortex, and used to assess language lateralization as well as for a resting-state connectivity analysis. Furthermore, the association between connection strength and language performance was investigated.

RESULTS: Reduced language performance was found in the children with RE. Bilateral activation was found for both language tasks with some predominance of the left hemisphere in both groups. Compared to controls, patient connectivity was decreased between the left sensorimotor area and right inferior frontal gyrus ($p < 0.01$). For this connection, lower connectivity was associated with lower language scores in the patient group ($r = 0.49$, $p = 0.02$), but not in the controls.

CONCLUSION: Language laterality analysis revealed bilateral language representation in the age range under study (8-14 years). As a consequence, the connection of reduced functional connectivity we found represents an impaired interplay between motor and language networks, and aberrant functional connectivity associated with poorer language performance. These findings provide a first neuronal correlate in terms of aberrant resting-state functional connectivity for language impairment in RE.

Copyright © 2013 Elsevier B.V. All rights reserved.

KEYWORDS:

Benign rolandic epilepsy of childhood with centro temporal spikes, Language impairment, RE, Resting-state functional MRI, rolandic epilepsy

Publication Types

LinkOut - more resources

0 comments

(i. encl. 7)

24

Education Commission For Foreign Medical Graduates
(ECFMG)
3624 Market Street
Philadelphia, PA 19104-2685

William Lupardo Director for the Office
of Services for Students with Disabilities
SUNY College at Old Westbury

March 31, 2014

Re: Richard Katz
ECFMG ID: #06314751

Subject: Six Attempt Limit for USMLE Examinations: USMLE STEP I

To Whom It May Concern::

My name is William Lupardo, I was Director for the Office of Services for Students with Disabilities at the State University of New York College at Old Westbury from September 1995 through August of 2005. Richard consulted the Disability Services as he was having difficulty organizing his thoughts during timed examinations, he supplied a doctors note to Disability Services with a diagnosis of Test Anxiety, a physiological condition in which people experience extreme stress, anxiety, and discomfort during and/or before taking a test. In order to accommodate Richard's condition additional testing time with supervision at our center was arranged in cooperation with Richard's professors at the College.

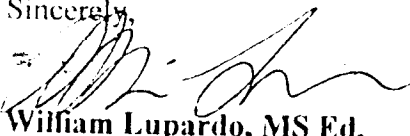
Disability Services also submitted a letter to The National Board of Medical Examiners (NBME) in May of 2005 on Richard's behalf in order to demonstrate that Richard Katz had received exam accommodations in the past, during his pre-med coursework. At that time Richard was applying for exam accommodations for the USMLE Step I exam under a diagnosis of ADHD.

I recently learned that Richard Katz does not suffer from ADHD but actually suffers from bipolar disorder. Richard first learned of his bipolar disorder in March of 2013. This may explain many of the difficulties that Richard experienced while doing his pre-med coursework at SUNY College at Old Westbury.

As an individual who spent many years supporting students in developing skills, learning about resources, and gaining the confidence needed to maintain a balanced and independent lifestyle that is essential to meeting career and life objectives, I feel that Richard Katz deserves a chance to sit for his medical licensing exams with exam accommodations. Richard reports that he has spent the last nine years in limbo since graduating Medical School in 2004 working to pass his medical licensing exams. In my opinion, the only thing that has been tested is Richard's fortitude as it relates to his disability.

If you have any further questions feel free to contact me at (516) 935-0006.

Sincerely,



William Lupardo, MS Ed.

Director

Sunrise Career Institute, Inc.
1445 New York Avenue
Huntington Station, NY 11746
(516) 935-000

PAUL LERNER, M.D.

28-49 37th Street, Astoria, New York 11103 (718) 726-5340
1575 Hillside Avenue, New Hyde Park, New York 11040 (516) 352-2441

05/15/2007

Gary Goldberg, DC,
104-20 Queens Blvd Ste 1 W
Forest Hills, NY 11375

(i. encl. 8)

Neurological Report by Paul
Lerner, MD dated 5/15/2007

Dear Dr. Goldberg:

Dr. Richard Katz was seen in my office in consultation as requested by you for evaluation and care. The following is a summary of my findings and recommendations:

This 37 year old right handed male presents today for lower back pain, neck pain, headache and right shoulder pain following involvement in a motor vehicle accident that occurred on 02/06/2007 as a seatbelted driver. He reports no airbag deployment. He reports no loss of consciousness. Currently he describes neck and low back pain that is constant and worse with movement. Pain radiates from the neck into the right arm, right shoulder and right scapula. He denies incontinence, headache, vertigo, auditory disturbances, visual disturbances and nausea.

Past Medical History: ADHD. No other serious illness or other trauma.

Medication: Advil, acetaminophen.

Allergies: No known medical allergies.

Social History: He denies smoking, alcohol abuse, and illicit drug use. The patient's main occupation is a psychiatrist.

Family History: Patient admits a family history of heart problems.

Review of Systems: No abnormal findings with the exception of the chief complaint.

EXAMINATION:

General Physical Exam: The head and neck are normal and atraumatic in appearance. Active range of motion at the head is observed to reveal a moderate degree of restriction in all directions associated with discomfort. Pulses are strong and regular. There is discomfort reported to percussion of the spine and palpation of the paravertebral muscles.

Mental Status: Higher cognitive functions are grossly intact.

Cranial Nerves: Olfaction is normal. The pupils are equal and reactive, the visual fields are full and funduscopy examination is normal. Extraocular muscle function is normal without nystagmus. Muscles of mastication are strong. Facial sensation is normal and corneal reflexes are present. The face, tongue and palate are symmetric. Hearing is grossly intact. The accessory muscles are strong.

Motor: Muscle strength is 5/5 for all groups tested. There are no fasciculations, tremors or

dysmetria and muscle tone is normal in the extremities. Spasm is present at the thoracolumbar paraspinal muscles and cervical paraspinal muscles.

Sensory: Touch, pin, vibratory and proprioception sensations are normal. There is no abnormality to double simultaneous tactile stimulation and higher sensory function are intact.

Reflexes: Deep tendon reflexes are normal and symmetric. Left ankle clonus.

Locomotor: The gait and station are normal and steady without parkinsonian features, ataxia and circumduction. Romberg's sign is absent.

Impression:

Cervical myeloradiculopathy. Lumbar strain

Recommendations and Plan:

MRI of the lumbar spine is recommended to evaluate for structural abnormality such as intervertebral disk herniation(s). C-spine MRI report requested for review. Electrodiagnostic testing of the upper and lower extremities is recommended to evaluate the severity and identify suspected neuropathic injury/abnormality. Chiropractic care is recommended. medrol is prescribed. Side effects and dosing discussed. **Scheduling:** Return to the office in 2 week(s).

If I may be of any further assistance in the care of your patient, please let me know. Thank you for providing me the opportunity to participate in the care of your patients.

Sincerely,

Paul Lerner, MD

Paul Lerner, M.D., P.C.

FILE ID: XXXXX7526SU

4.7.1b

16 MAY 07 17:16

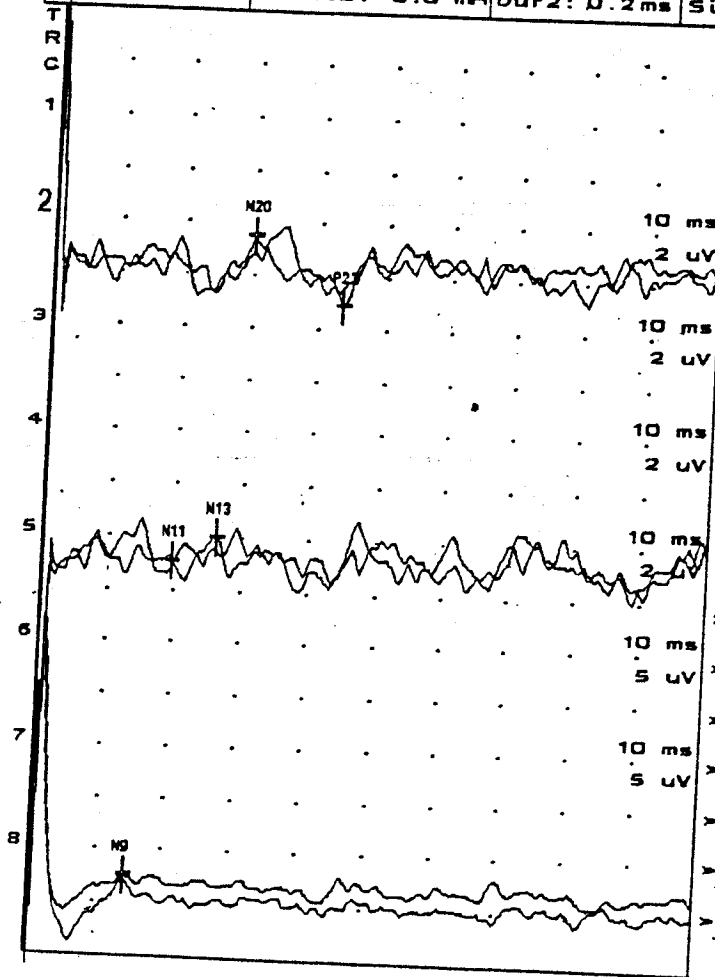
SEP

1 Katz, Richard

Median Nerve. 3 Ch

17:16:21

STIM: OFF	AVG: OFF	TRC 2:	Lat1: 0.0 ms	Lat2: ms	Diff: ms
STIM: Recur	Level1: 12.6 mA	Dur1: 0.2 ms	Amp1: 19.77 uV	Amp2: uV	Diff: uV
Rate: 5.1 Hz	Level2: 0.0 mA	Dur2: 0.2 ms	Single		Delay1: 0.00 ms
			Single		Delay2: 0.00 ms



	LAT ms	LAT ms	AMP uV		
2	N20	P23	N20 P23		
	30.0	43.4	2.575		
4	N11	N13			
	19.6	26.2			
6	N9				
	14.4				

>Interpeak Latencies

	IPI LAT ms		
6-2	N9 N20		
	15.6		
4-2	N13 N20		
	3.8		
6-4	N9 N13		
	11.8		

Paul Lerner, M.D., P.C.

FILE ID: XXXXX7526SU

4.7.1b

16 MAY 07 17:15

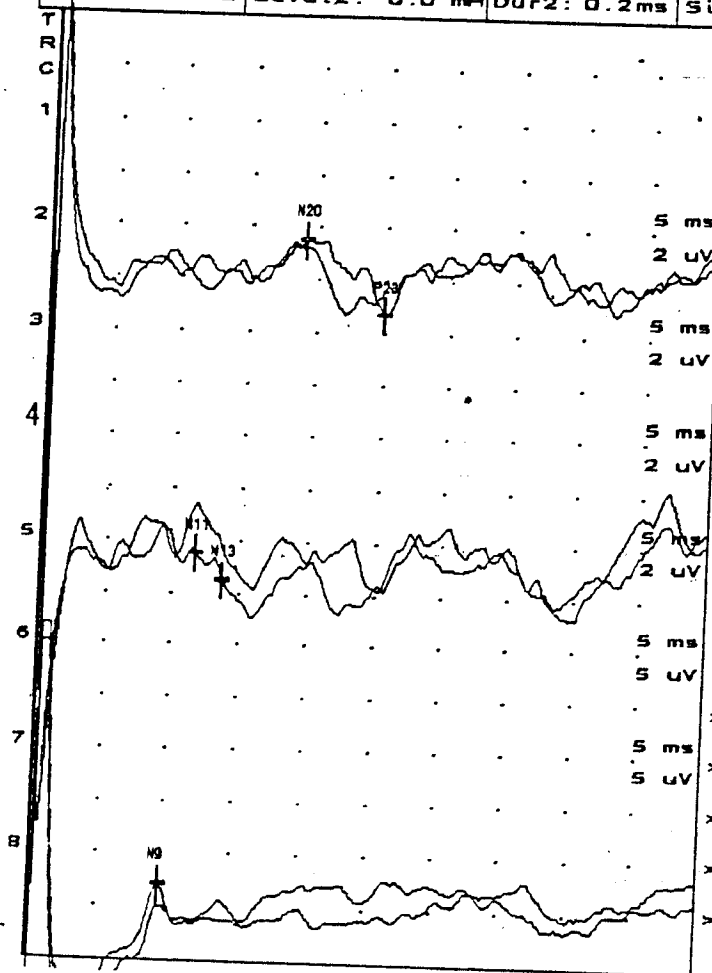
SEP

2 Katz, Richard

Median Nerve. 3 Ch.L

17:15:44

STIM: OFF	AVG: OFF	TRC 4:	Lat1: 0.0 ms	Lat2: ms	Diff: ms
STIM: Recur	Level1: 12.6 mA	Dur1: 0.2ms	Amp1: 0.650 uV	Amp2: uV	Diff: uV
Rate: 5.1 Hz	Level2: 0.0 mA	Dur2: 0.2ms	Single	Delay1: 0.00 ms	Delay2: 0.00 ms



	LAT ms	LAT ms	AMP uV		
2 N20	39.0	P23 50	N20 P23		
4 N1123		N13	2.810		
6 N9	3.9				

>Interpeak Latencies

	IPI LAT ms		
6-2	N9 N20		
	9.2		
4-2	N13 N20		
	5.3		
6-4	N9 N13		
	3.9		

Paul Lerner, M.D., P.C.

FILE ID: XXXXX7526SU

4.7.1b

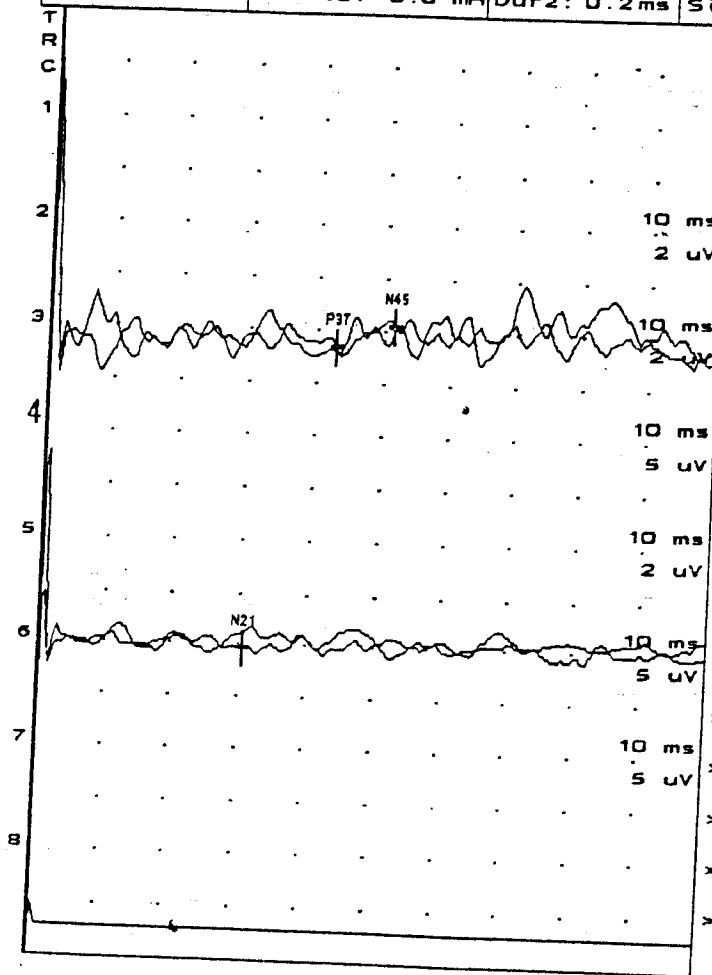
15 MAY 07 17:12

SEP

3 Katz, Richard

Posterior Tibial Nerve .R 17:12:14
3 Ch.R

STIM: OFF	AVG: OFF	TRC 4:	Lat1: 0.0 ms	Lat2: ms	Diff: ms
			Amp1: 21.07 uV	Amp2: uV	Diff: uV
STIM: Recur	Level1: 12.6 mA	Dur1: 0.3 ms	Single		
Rate: 2.3 Hz	Level2: 0.0 mA	Dur2: 0.2 ms	Single		
				Delay1: 0.00 ms	
				Delay2: 0.00 ms	



	LAT ms	LAT ms				
2	P37	N45				
	42.8	51.4				
4	N21					
	30.6					
6	PF					

>Interpeak Latencies

	IPI LAT ms		
6-2	PF P37		
4-2	N21 P37		
	12.2		
6-4	PF N21		

Paul Lerner, M.D., P.C.

FILE ID: XXXXX7526SU

4.7.1b

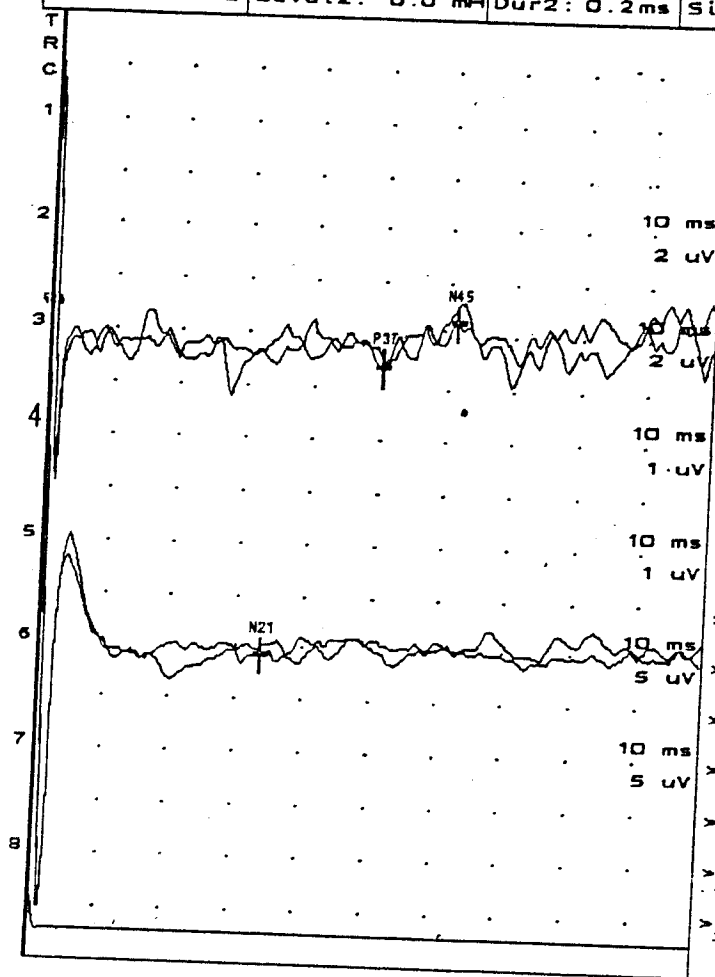
15 MAY 07 17:13

SEP

4 Katz, Richard

Posterior Tibial Nerve .L 17:13:21
3 Ch.L

STIM: OFF	AVG: OFF	TRC 4:	Lat1: 0.0 ms	Lat2: ms	Diff: ms
STIM: Recur	Level1: 12.6 mA	Dur1: 0.3ms	Amp1: -0.100 uV	Amp2: uV	Diff: uV
Rate: 2.3 Hz	Level2: 0.0 mA	Dur2: 0.2ms	Single		Delay1: 0.00ms
			Single		Delay2: 0.00ms



	LAT ms	LAT ms				
2	P37	N45				
	50.0	61.2				
4	N21					
	33.6					
6	PF					

>Interpeak Latencies

	IPI LAT ms		
6-2	PF P37		
4-2	N21 P37		
	16.4		
6-4	PF N21		

Somatosensory Evoked Potentials:

Posterior Tibial Nerve .L 3 Ch.L

Trace	Label	Amplifier	SNS/d	LFF	HFF
2	Cz'-Fpz	1	10uV	10Hz	3kHz
3		1	10uV	10Hz	3kHz
4	Lumbar-Ref	2	5uV	30Hz	3kHz
5		2	5uV	30Hz	3kHz
6	PF-Ref	3	10uV	30Hz	3kHz
7		3	10uV	30Hz	3kHz

Trace	Label	Sweeps Averaged	Date	Time	Stimulus Parameters
2	Cz'-Fpz	200	15 MAY 07	17:02:06	12.6 mA 0.3 ms / 0.0 mA 0.2 ms
3		548	15 MAY 07	17:03:34	12.6 mA 0.3 ms / 0.0 mA 0.2 ms
4	Lumbar-Ref	200	15 MAY 07	17:02:06	12.6 mA 0.3 ms / 0.0 mA 0.2 ms
5		548	15 MAY 07	17:03:34	12.6 mA 0.3 ms / 0.0 mA 0.2 ms
6	PF-Ref	200	15 MAY 07	17:02:06	12.6 mA 0.3 ms / 0.0 mA 0.2 ms
7		548	15 MAY 07	17:03:35	12.6 mA 0.3 ms / 0.0 mA 0.2 ms

Measurement Table:

	LAT ms	LAT ms
2	P37 50.0	N45 61.2
4	N21 33.6	
6	PF	
Interpeak Latencies		
	IPI LAT ms	
6-2	PF P37	
4-2	N21 P37 16.4	
6-4	PF N21	

Conclusions:

There is a delay of cortical response to both left upper and lower extremity stimulation.